

		FOR OHF USE				

LL 1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0025023</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Lutheran Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/01</u> to <u>9/30/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>702 West Cumberland</u> <u>Altamont</u> <u>62411</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Effingham</u>		(Signed) _____ (Date) _____	
Telephone Number: <u>(618) 483-6136</u> Fax # <u>(618) 483-5607</u>		(Type or Print Name) _____	
IDPA ID Number: <u>371072628001</u>		(Title) _____	
Date of Initial License for Current Owners: <u>10/01/80</u>		(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____	
Type of Ownership:		(Print Name and Title) _____	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>	
<input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust		(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>	
IRS Exemption Code <u>501(c)(3)</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
<input type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____			
<input type="checkbox"/> GOVERNMENTAL			
<input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center# 0025023 Report Period Beginning: 10/1/01 Ending: 9/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>96</u>	Skilled (SNF)	<u>96</u>	<u>35,040</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>96</u>	TOTALS	<u>96</u>	<u>35,040</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,621</u>	<u>4,893</u>	<u>1,842</u>	<u>10,356</u>	8
9	SNF/PED					9
10	ICF	<u>7,434</u>	<u>9,462</u>		<u>16,896</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,055</u>	<u>14,355</u>	<u>1,842</u>	<u>27,252</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 77.77%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒NO ☐

I. On what date did you start providing long term care at this location?

Date started 10/01/80

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 10/01/80NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 6 and days of care provided 1,842Medicare Intermediary Mutual of Omaha Insurance Company

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☐NO ☐Tax Year: 9/30/02 Fiscal Year: 9/30/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Lutheran Care Center

0025023

Report Period Beginning:

10/1/01

Ending:

9/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	227,240	14,960	6,561	248,761		248,761		248,761			1
2	Food Purchase		133,066		133,066		133,066	(4,027)	129,039			2
3	Housekeeping	74,854	12,897		87,751		87,751		87,751			3
4	Laundry	68,291	10,535	263	79,089		79,089		79,089			4
5	Heat and Other Utilities			60,825	60,825		60,825		60,825			5
6	Maintenance	26,654	3,169	22,605	52,428		52,428		52,428			6
7	Other (specify):*											7
8	TOTAL General Services	397,039	174,627	90,254	661,920		661,920	(4,027)	657,893			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	997,477	82,461	2,303	1,082,241		1,082,241		1,082,241			10
10a	Therapy	123,247	237	4,859	128,343		128,343		128,343			10a
11	Activities	50,314	1,368	1,290	52,972		52,972		52,972			11
12	Social Services	41,806	883	540	43,229		43,229		43,229			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,212,844	84,949	11,392	1,309,185		1,309,185		1,309,185			16
	C. General Administration											
17	Administrative	49,945			49,945		49,945		49,945			17
18	Directors Fees											18
19	Professional Services			44,957	44,957		44,957		44,957			19
20	Dues, Fees, Subscriptions & Promotions			6,777	6,777		6,777	(75)	6,702			20
21	Clerical & General Office Expenses	93,227	4,141	25,051	122,419		122,419	(2,576)	119,843			21
22	Employee Benefits & Payroll Taxes			441,407	441,407		441,407	(1,086)	440,321			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,086	11,086		11,086		11,086			24
25	Other Admin. Staff Transportation			2,046	2,046		2,046		2,046			25
26	Insurance-Prop.Liab.Malpractice			69,160	69,160		69,160		69,160			26
27	Other (specify):*											27
28	TOTAL General Administration	143,172	4,141	600,484	747,797		747,797	(3,737)	744,060			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,753,055	263,717	702,130	2,718,902		2,718,902	(7,764)	2,711,138			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			106,342	106,342		106,342	(2,415)	103,927			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,597	7,597		7,597	(7,597)				32
33	Real Estate Taxes			174	174		174	(174)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,199	1,199		1,199		1,199			35
36	Other (specify):*											36
37	TOTAL Ownership			115,312	115,312		115,312	(10,186)	105,126			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		32,025	2,917	34,942		34,942		34,942			39
40	Barber and Beauty Shops			14,375	14,375		14,375		14,375			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,560	52,560		52,560		52,560			42
43	Other (specify):* Nonallowable Costs	102,385	25,460	269,399	397,244		397,244	(397,244)				43
44	TOTAL Special Cost Centers	102,385	57,485	339,251	499,121		499,121	(397,244)	101,877			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,855,440	321,202	1,156,693	3,333,335		3,333,335	(415,194)	2,918,141			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

** See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(3,741)	2		4
5 Telephone, TV & Radio in Resident Rooms	(1,025)	43		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	(2,415)	30		9
10 Interest and Other Investment Income	(7,597)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)	(1,331)	43		16
17 Non-Care Related Fees	(174)	33		17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(2,744)	43		24
25 Fund Raising, Advertising and Promotional	(13,604)	43		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See Schedule 5A	(382,563)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (415,194)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)			34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (415,194)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lutheran Care Center

ID# 0025023

Report Period Beginning: 10/1/01

Ending: 9/30/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Lutheran Care Center
Provider # - 0025023
Fiscal Year End - 9/30/02

Schedule 5A

VI. Adjustment Detail

Other Non-Allowable Expenses	Amount	Reference
Miscellaneous Expense Offset	(2,576)	21
Offset Employee Uniform Income	(1,086)	22
Offset Vending Machine Income	(286)	2
Non-allowable Dues and Subscriptions	(75)	20
Luther Villas Salaries and Wages	(56)	43
Luther Villas Supplies Expense	(131)	43
Luther Villas Other Expense	(47,289)	43
Luther Terrace Salaries & Wages Expense	(102,329)	43
Luther Terrace Supplies Expense	(25,329)	43
Luther Terrace Other Expense	(203,406)	43
Total	<u>\$ (382,563)</u>	

See Accountants' Compilation Report

Summary A

9/30/02

[illegible]

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lutheran Care Center# 0025023

Report Period Beginning:

10/1/01

Ending:

9/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(2,415)	0	0	0	0	0	0	0	0	0	0	(2,415)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,597)	0	0	0	0	0	0	0	0	0	0	(7,597)	32
33	Real Estate Taxes	(174)	0	0	0	0	0	0	0	0	0	0	(174)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(10,186)	0	0	0	0	0	0	0	0	0	0	(10,186)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(18,704)	0	0	0	0	0	0	0	0	0	0	(18,704)	43
44	TOTAL Special Cost Centers	(18,704)	0	0	0	0	0	0	0	0	0	0	(18,704)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(32,631)	0	0	0	0	0	0	0	0	0	0	(32,631)	45

Facility Name & ID Number Lutheran Care Center# 0025023

Report Period Beginning:

10/1/01

Ending:

9/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		N/A				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V				N/A				2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/01 Ending: 9/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3		See attached schedule for Board of Directors									3
4		Note: No members of the Board provided services to the nursing home									4
5		Note: No members of the Board owned businesses that provided services to the nursing home									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center# 0025023

Report Period Beginning:

10/1/01

Ending:

9/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (____) _____

Fax Number (____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4			N/A						4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center# 0025023

Report Period Beginning:

10/1/01

Ending:

9/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	\$		\$		9
	B. Non-Facility Related*											
10	First Mid-Illinois Bank & Trust		x	Luther Terrace mortgage		6/16/97	1,000,000	932,608	6/15/27	0.0720	72,460	10
11											(2,067)	11
12											(70,393)	12
13												13
14	TOTAL Non-Facility Related						\$ 1,000,000	\$ 932,608			\$	14
15	TOTALS (line 9+line14)						\$ 1,000,000	\$ 932,608			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Page 10
9/30/02**SEE ACCOUNTANTS' COMPILATION REPORT**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lutheran Care Center COUNTY Effingham

FACILITY IDPH LICENSE NUMBER 0025023

CONTACT PERSON REGARDING THIS REPORT Karen Hille

TELEPHONE (618) 483-6136 FAX #: (618) 483-5607

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>N/A</u>	<u></u>	\$ <u></u>	\$ <u></u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u></u>	\$ <u></u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A.

Square Feet:

25,884

B.

General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

1

C.

Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Luther Villas - Independent Living

7 units -7,700 square feet

Luther Terrace - Independent Living

16 units - 13, 688 square feet

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized:

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	239,085	1980	\$ 35,000	1
2	Resident Care	197,415	1987	28,900	2
3	TOTALS	436,500		\$ 63,900	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center

0025023

Report Period Beginning:

10/1/01

Ending:

9/30/02

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	96	1980	1969	\$ 867,500	\$ 34,700	25	\$ 34,700	\$	\$ 763,400
5		1980	1969	12,000	480	25	480		10,560
6		1980	1974	141,000	5,640	25	5,640		124,080
7		1980	1969	10,000		25	400	400	9,000
8		1980	1977	1,000		25	40	40	900
Improvement Type**									
9	Therapy Room		1981	3,764	151	25	151		3,187
10	Land Improvements		1980	28,500	1,210	25	1,140	(70)	26,462
11	Land Improvements		1986	2,000	80	25	80		1,246
12	Land Improvements		1987	2,143	86	25	86		1,350
13	Land Improvements		1991	491	20	25	20		295
14	Building Improvements		1981	3,486		5			3,486
15	Building Improvements		1982	6,557	136	20	136		6,557
16	Building Improvements		1982	163		10			163
17	Building Improvements		1985	940		10			940
18	Building Improvements		1985	2,512	126	20	126		2,143
19	Building Improvements		1986	955		10			955
20	Building Improvements		1986	1,949	97	20	97		1,634
21	Building Improvements		1987	2,150		10			2,150
22	Building Improvements		1987	1,023	51	20	51		776
23	Building Improvements		1988	1,500		10			1,500
24	Building Improvements		1989	16,021		10			16,021
25	Building Improvements		1989	241	16	15	16		213
26	Building Improvements		1989	14,979		20			14,979
27	Building Improvements		1990	6,315		5			6,315
28	Building Improvements		1990	20,381		10			20,381
29	Building Improvements		1990	10,176	678	15	678		8,311
30	Building Improvements		1990	1,656	83	20	83		1,014
31	Building Improvements		1991	6,000		10			6,000
32	Building Improvements		1992	7,122		7			7,122
33	Building Improvements		1992	4,345	326	10	326		4,345
34	Misc Flooring/ Wallpaper		1993	3,762		5			3,762
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Lutheran Care Center

0025023

Report Period Beginning:

10/1/01

Ending:

9/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Dining Room	1993	\$ 82,632	\$ 2,623	31.5	\$ 2,623	\$	\$ 23,281		37
38	Sprinkler System	1994	31,932	798	40	798		6,558		38
39	Additional Patio Work	1994	1,725	43	40	43		351		39
40	Dining Room Floor	1994	2,788	70	40	70		571		40
41	Breakroom Wallpaper	1994	302	8	40	8		65		41
42	Admin Office Wallpaper	1994	381	10	40	10		80		42
43	Lobby Wall Covering	1994	2,759	69	40	69		564		43
44	Floor Tile	1994	683	17	40	17		139		44
45	Misc. Bldg. Improvements	1994	1,408	35	40	35		286		45
46	Land Imp. - Sewer Line	1994	7,949	199	40	199		1,641		46
47	Land Imp. - Drainage Pipe	1994	860	21	40	21		174		47
48	Misc. Land Improvements	1994	1,279	32	40	32		264		48
49	Building Improvements	1995	7,804	200	40	200		1,487		49
50	Carpet for Lobby	1995	1,465	146	10	146		952		50
51	Office Wallpaper	1995	622	62	10	62		405		51
52	Front Office Wallpaper	1995	825	82	10	82		536		52
53	Activity Office Counter Top	1995	1,575	157	10	157		1,024		53
54	Flooring North Hall	1996	717	72	10	72		466		54
55	Air Conditioner Unit	1996	8,400	840	10	840		5,460		55
56	Air Conditioner Unit	1996	940	94	10	94		611		56
57	Air Conditioner Unit	1996	560	56	10	56		364		57
58	Gas Line	1996	947	95	10	95		616		58
59	Flooring Halls	1995	1,822	182	10	182		1,138		59
60	Flooring Halls	1994	1,267	127	10	127		793		60
61	Fire Alarm System	1996	2,429	243	10	243		1,579		61
62	Building Improvements	1996	697	70	10	70		453		62
63	Parking lot improvements	1997	1,500	75	20	75		413		63
64	Parking lot improvements	1997	2,510	251	10	251		1,381		64
65	Electrical wiring	1997	1,171	117	10	117		644		65
66	5 ton air conditioner unit	1997	5,330	533	10	533		2,932		66
67	Front entrance awning	1997	2,867	287	10	287		1,577		67
68	Electrical wiring	1997	966	97	10	97		531		68
69										69
70	TOTAL (lines 4 thru 69)		\$ 1,359,743	\$ 51,591		\$ 51,961	\$ 370	\$ 1,106,583		70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number Lutheran Care Center

0025023

Report Period Beginning:

10/1/01

Ending:

9/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,359,743	\$ 51,591		\$ 51,961	\$ 370	\$ 1,106,583	1
2	New administrative offices	1997	77,471		40	2,905	2,905	5,403	2
3	Dietary refrigeration system	1997	18,095	2,431	10	1,810	(621)	10,278	3
4	Cabinets & counter tops	1997	11,664	1,166	10	1,166		6,415	4
5	Roof	1998	178,417	8,921	20	8,921		40,144	5
6	Dry wall, blinds, flooring, paint, closets (Remodeling-Medicare Rooms)	1998	2,445	122	20	122		550	6
7	Plumbing, blinds, lighting (Remodeling - Medicare Rooms)	1998	384	122	10	38	(84)	381	7
8	Plumbing, paint, lumber (Remodeling-Medicare Room)	1998	834	472	10	83	(389)	374	8
9	Plumbing, carpeting, blinds, lumber (Remodeling-Medicare Room)	1998	3,548	694	10	355	(339)	1,598	9
10	Plumbing, shelving, paint, draperies, cabinets, wall coverings (Medicare R	1998	2,576	354	10	258	(96)	1,402	10
11	Parking lot improvements	1998	1,298	130	10	130		584	11
12									12
13	Building Improvements - per 1994 audit	1981	1,140		10			1,140	13
14	Building Improvements - per 1994 audit	1982	2,159		10			2,159	14
15	Building Improvements - per 1994 audit	1984	1,677		10			1,677	15
16									16
17	Landscaping	1999	4,080	204	20	204		714	17
18	Electrical, lighting (Remodeling -Medicare Rooms)	1999	295	30	10	30		103	18
19	Dry wall (Remodeling-Medicare Rooms)	1999	196	20	10	20		69	19
20	Closets (Remodeling-Medicare Rooms)	1999	1,474	211	10	211		737	20
21	Phone jacks, shelving, paint (Remodeling-Medicare Rooms)	1999	652	65	10	65		228	21
22	Cove base (Medicare room remodeling)	1999	77	8	10	8		27	22
23	Plumbing, gas line (Laundry Expansion)	1999	3,156	158	20	158		552	23
24	Concrete, roof, lumber, building materials (Laundry Expansion)	1999	7,063	353	20	353		1,236	24
25	Brick work (Laundry Expansion)	1999	4,553	227	20	227		797	25
26	Concrete, roof, gas line, building materials (Laundry Expansion)	1999	2,708	135	20	135		474	26
27	Air Conditioner Improvements	1999	677	135	5	135		474	27
28	Wallcoverings, hand rails, chair rails (Remodeling - Medicare Rooms)	2000	1,684	168	10	168		421	28
29	Drywall, wall coverings, paint (Remodeling - Medicare Rooms)	2000	2,056	206	10	206		514	29
30	Hardware supplies (Remodeling - Medicare Rooms)	2000	59	6	10	6		18	30
31	Wallcoverings, draperies, chair rails (Remodeling - Medicare Rooms)	2000	8,853	915	10	885	(30)	2,228	31
32	Wallcovering (Remodeling - Medicare Rooms)	2000	59	6	10	6		15	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,699,093	\$ 68,850		\$ 70,566	\$ 1,716	\$ 1,187,295	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward	\$ 1,699,093	\$ 68,850		\$ 70,566	\$ 1,716	\$ 1,187,295	1
2	Sidewalk	2000 2,300	263	20	115	115	288	2
3	Flooring	2002 6,306	61	10	263		263	3
4	Windows	2002 3,635	16	10	61		61	4
5	Seed for lawn	2001 425	40	20	16		16	5
6	Chapel	2002 414,840	221	10	865		865	6
7	Windows	2002 26,539	17	10	221		221	7
8	Sidewalk	2002 2,083	43	10	17		17	8
9	Cabinets	2002 9,246	52	10	77		77	9
10	Wiring	2002 5,107	14	10	43		43	10
11	Landscaping	2002 6,280	66	10	52		52	11
12	Screen	2002 1,716	66	10	14		14	12
13	Cable	2002 7,954	41	10	66		66	13
14	Door guard	2002 4,955			41		41	14
15								15
16								16
17								17
18								18
19	Miscellaneous depreciation difference		4,082			(4,082)		19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,190,479	\$ 74,668		\$ 72,417	\$ (2,251)	\$ 1,189,319	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 142,283	\$ 20,953	\$ 20,847	\$ (106)	5-7 Yrs	\$ 120,306	71
72	Current Year Purchases	31,889	1,585	1,585		5-7 Yrs	1,585	72
73	Fully Depreciated Assets	383,758				5-7 Yrs	383,758	73
74								74
75	TOTALS	\$ 557,930	\$ 22,538	\$ 22,432	\$ (106)		\$ 505,649	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2001 Dodge E250 Van	2001	\$ 39,825	\$ 7,965	\$ 7,965		5	\$ 11,763	76
77	Facility Use	1990 Oldsmobile Wagon	2001	3,340	1,113	1,113		3	1,670	77
78										78
79										79
80	TOTALS			\$ 43,165	\$ 9,078	\$ 9,078			\$ 13,433	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,855,474	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 106,284	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 103,927	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,357)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,708,401	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Net Fixed Assets	\$	\$	\$	86
87	Luther Villas & Luther Terrace	1,442,898	47,513	280,487	87
88					88
89					89
90					90
91	TOTALS	\$ 1,442,898	\$ 47,513	\$ 280,487	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

10. Effective dates of current rental agreement:

Beginning

Ending _____

11. Rent to be paid in future years under the current rental agreement:

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: _____

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 1,199 Description: Dishwasher - \$1,199

(Attach a schedule detailing the breakdown of movable equipment)

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. /2003 \$

13. /2004 \$

14. _____/2005 \$ _____

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

*** If there is an option to buy the building, please provide complete details on attached schedule.**

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist	L10a, C1,2	285	hrs	\$ 4,271		\$	118	285	\$ 4,389	1				
2	Licensed Speech and Language Development Therapist	L10a, C3		hrs		71	4,774		71	4,774	2				
3	Licensed Recreational Therapist			hrs							3				
4	Licensed Physical Therapist	L10a, C1, 2, & 3	7919	hrs	118,976	1	85	119	7,920	119,180	4				
5	Physician Care			visits							5				
6	Dental Care			visits							6				
7	Work Related Program			hrs							7				
8	Habilitation			hrs							8				
9	Pharmacy	L39, C2		# of prescripts				32,025		32,025	9				
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10				
11	Academic Education			hrs							11				
12	Exceptional Care Program										12				
13	Other (specify): Laboratory	L39, C3					2,917			2,917	13				
14	TOTAL				\$ 123,247	72	\$ 7,776	\$ 32,262	8,276	\$ 163,285	14				

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 507,436	\$ 507,436	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	379,753	379,753	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,791	4,791	6
7	Other Prepaid Expenses	18,355	18,355	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Contribution receivable	340,000	340,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,250,335	\$ 1,250,335	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	63,710	63,900	13
14	Buildings, at Historical Cost	2,130,231	2,190,479	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	590,924	601,095	16
17	Accumulated Depreciation (book methods)	(1,671,571)	(1,708,401)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: Mortgage Costs)	7,072	7,072	22
23	Other(specify): Net F/A - Villas & Terrace	1,234,479	1,162,411	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,354,845	\$ 2,316,556	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,605,180	\$ 3,566,891	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 45,544	\$ 45,544	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,520	4,520	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	144,800	144,800	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,357	19,357	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,915	2,915	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Employee Withholdings	2,407	2,407	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 219,543	\$ 219,543	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	932,608	932,608	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Revenue	158,480	158,480	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,091,088	\$ 1,091,088	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,310,631	\$ 1,310,631	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,294,549	\$ 2,256,260	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,605,180	\$ 3,566,891	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,933,286	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,933,286	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	361,263	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 361,263	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,294,549	24

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Lutheran Care Center

0025023

Report Period Beginning: 10/1/01

Ending:

Page 19

9/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,462,650	1
2	Discounts and Allowances for all Levels	88,380	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,551,030	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	197,310	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 197,310	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	14,179	13
14	Non-Patient Meals	8,609	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	48,277	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,050	19
20	Radiology and X-Ray		20
21	Other Medical Services	71,571	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 147,686	23
	D. Non-Operating Revenue		
24	Contributions	433,051	24
25	Interest and Other Investment Income***	3,811	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 436,862	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental of Independent Living Units	360,932	28
28a	Miscellaneous Income	778	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 361,710	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,694,598	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	661,920	31
32	Health Care	1,309,185	32
33	General Administration	747,797	33
	B. Capital Expense		
34	Ownership	115,312	34
	C. Ancillary Expense		
35	Special Cost Centers	446,561	35
36	Provider Participation Fee	52,560	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,333,335	40
41	Income before Income Taxes (line 30 minus line 40)**	361,263	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 361,263	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.
Lutheran Care Center is a Not-For-Profit entity.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Lutheran Care Center**# **0025023**Report Period Beginning: **10/1/01**Ending: **9/30/02**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,888	2,128	\$ 38,135	\$ 17.92	1
2	Assistant Director of Nursing	2,033	2,175	35,454	16.30	2
3	Registered Nurses	5,183	5,816	87,965	15.12	3
4	Licensed Practical Nurses	15,400	17,069	207,783	12.17	4
5	Nurse Aides & Orderlies	60,684	65,810	549,004	8.34	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,187	4,548	88,367	19.43	7
8	Rehab/Therapy Aides	3,695	4,112	34,880	8.48	8
9	Activity Director	1,853	2,026	21,266	10.50	9
10	Activity Assistants	3,442	3,504	29,048	8.29	10
11	Social Service Workers	3,752	4,002	41,806	10.45	11
12	Dietician	1,740	1,921	23,258	12.11	12
13	Food Service Supervisor	1,743	1,927	18,995	9.86	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,827	25,790	184,987	7.17	15
16	Dishwashers					16
17	Maintenance Workers	3,197	3,620	26,654	7.36	17
18	Housekeepers	9,627	10,631	74,854	7.04	18
19	Laundry	7,840	8,575	68,291	7.96	19
20	Administrator	1,854	2,073	49,945	24.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,954	2,134	30,522	14.30	23
24	Clerical	5,489	6,140	62,705	10.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: See Sch 20A	5,621	6,171	79,136	12.82	32
33	Other(specify) See Sch 20A	11,681	12,797	102,385	8.00	33
34	TOTAL (lines 1 - 33)	176,690	192,969	\$ 1,855,440 *	\$ 9.62	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	122	\$ 5,361	L1, C3	35
36	Medical Director	208	2,400	L9, C3	36
37	Medical Records Consultant	20	1,540	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	495	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	9	486	L11, C3	44
45	Social Service Consultant	9	486	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	464	\$ 10,768		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Lutheran Care Center
Provider # - 0025023
Fiscal Year End - 9/30/02

Schedule 20A

XVIII. A. Staffing and Salary Costs

Line 32 Other Health Care:

	# of Hours Worked	# of Hours Paid	Total Salaries/Wage s	Avg. Hourly Wage
Care Plan Nurse	2,032	2,201	\$ 33,642	15.28
Quality Assurance Coordinator	1,836	2,065	\$ 30,311	14.68
Ward Clerk	1,753	1,905	\$ 15,183	7.97
Total	5,621	6,171	79,136	12.82

Line 33 Other:

	# of Hours Worked	# of Hours Paid	Total Salaries/Wage s	Avg. Hourly Wage
Independent Living Wages	11,681	12,797	\$ 102,385	8.00
Total	11,681	12,797	102,385	8.00

See Accountants' Compilation Report

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
Karen Hille	Administrator	0%	\$ 49,945	Workers' Compensation Insurance		\$ 77,004	IDPH License Fee		\$		
				Unemployment Compensation Insurance		5,626	Advertising: Employee Recruitment		942		
				FICA Taxes		129,321	Health Care Worker Background Check (Indicate # of checks performed <u>30</u>)		360		
				Employee Health Insurance		211,527	Life Services Network Dues		3,662		
				Employee Meals			Various Licenses and Fees		1,217		
				Illinois Municipal Retirement Fund (IMRF)*			Various Dues and Subscriptions		521		
				Employee Physicals		1,085					
				Employee Uniform Expense		238					
				Life Insurance		7,186					
				Other Employee Benefits		8,334					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 49,945				Less: Public Relations Expense		()		
B. Administrative - Other							Non-allowable advertising		()		
Description			Amount				Yellow page advertising		()		
N/A							TOTAL (agree to Sch. V, line 20, col. 8)		\$ 6,702		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 440,321					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description		Line #	Amount	Description		Amount	
ADP	Payroll Services		\$ 14,537				\$	Out-of-State Travel		\$	
Altschuler, Melvoin & Glasser, LLP	Accounting		18,857	N/A							
American Express Tax & Business Services	Accounting		1,907					In-State Travel		3,461	
Achieve	Computer Maintenance		7,945					See Attached Detail			
Taylor Law Offices	Legal		1,561								
Parker, Siemer, Austin, Resch & Fuhr	Legal		150					Seminar Expense		7,625	
								See Attached Detail			
								Entertainment Expense		()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 44,957	TOTAL			\$	(agree to Sch. V, line 24, col. 8)			
								TOTAL		\$ 11,086	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3							N/A						
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center

STATE OF ILLINOIS

0025023

Report Period Beginning:

10/1/01

Ending:

Page 23

9/30/02

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network of Illinois - \$3,662
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7.5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,634 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 52,560
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,741
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Altschuler, Melvoin & Glasser, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT

Lutheran Care Center

03:25 PM

11/04/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-415,194	equal to	-415,194	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	0	equal to	0	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	103,927	equal to	103,927	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	1,199	equal to	1,199	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv. - Staff Wages	123,247	equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	128,343	equal to	128,343	0	O.K.	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv. - Supplies	32,262	equal to	32,262	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	661,920	equal to	661,920	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,309,185	equal to	1,309,185	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	747,797	equal to	747,797	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	115,312	equal to	115,312	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	446,561	equal to	446,561	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	52,560	equal to	52,560	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	918,341	equal to	997,477	-79,136	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	88,367	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	50,314	equal to	50,314	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	41,806	equal to	41,806	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	227,240	equal to	227,240	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	26,654	equal to	26,654	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	74,854	equal to	74,854	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	68,291	equal to	68,291	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	49,945	equal to	49,945	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	93,227	equal to	93,227	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,855,440	equal to	1,855,440	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	5,361	< or = to	6,561	-1,200	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	2,400	< or = to	2,400	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	2,035	< or = to	2,303	-268	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	486	< or = to	1,290	-804	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	486	< or = to	540	-54	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	49,945	equal to	49,945	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to	0	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	44,957	equal to	44,957	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	440,321	equal to	440,321	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	6,702	equal to	6,702	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	11,086	equal to	11,086	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	52,560	equal to	52,560	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	-1,086	1,086	FAILED	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,842	equal to	1,842	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8
Total loan balance	932,608	equal to	932,608	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to	0	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	63,900	equal to	63,900	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,190,479	equal to	2,190,479	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	601,095	equal to	601,095	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,708,401	equal to	1,708,401	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	2,294,549	equal to	2,294,549	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	361,263	equal to	361,263	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,605,180	equal to	3,605,180	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Adjusted Total
1. Dietary	227,240	14,960	6,561	248,761	0	248,761	0	248,761
2. Food P	0	133,066	0	133,066	0	133,066	-4,027	129,039
3. Housek	74,854	12,897	0	87,751	0	87,751	0	87,751
4. Laundr	68,291	10,535	263	79,089	0	79,089	0	79,089
5. Heat ar	0	0	60,825	60,825	0	60,825	0	60,825
6. Mainte	26,654	3,169	22,605	52,428	0	52,428	0	52,428
7. Other (0	0	0	0	0	0	0	0
8. Total G	397,039	174,627	90,254	661,920	0	661,920	-4,027	657,893
9. Medical	0	0	2,400	2,400	0	2,400	0	2,400
10. Nursin	997,477	82,461	2,303	1,082,241	0	1,082,241	0	1,082,241
10a. Ther	123,247	237	4,859	128,343	0	128,343	0	128,343
11. Activi	50,314	1,368	1,290	52,972	0	52,972	0	52,972
12. Social	41,806	883	540	43,229	0	43,229	0	43,229
13. Nurse	0	0	0	0	0	0	0	0
14. Progr	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total I	1,212,844	84,949	11,392	1,309,185	0	1,309,185	0	1,309,185
17. Admin	49,945	0	0	49,945	0	49,945	0	49,945
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	44,957	44,957	0	44,957	0	44,957
20. Fees,	0	0	6,777	6,777	0	6,777	-75	6,702
21. Cleric	93,227	4,141	25,051	122,419	0	122,419	-2,576	119,843
22. Emplo	0	0	441,407	441,407	0	441,407	-1,086	440,321
23. Inserv	0	0	0	0	0	0	0	0
24. Travel	0	0	11,086	11,086	0	11,086	0	11,086
25. Other	0	0	2,046	2,046	0	2,046	0	2,046
26. Insura	0	0	69,160	69,160	0	69,160	0	69,160
27. Other	0	0	0	0	0	0	0	0
28. Total C	143,172	4,141	600,484	747,797	0	747,797	-3,737	744,060
29. Total C	1,753,055	263,717	702,130	2,718,902	0	2,718,902	-7,764	2,711,138
30. Depre	0	0	106,342	106,342	0	106,342	-2,415	103,927
31. Amort	0	0	0	0	0	0	0	0
32. Intere	0	0	7,597	7,597	0	7,597	-7,597	0
33. Real E	0	0	174	174	0	174	-174	0
34. Rent -	0	0	0	0	0	0	0	0
35. Rent -	0	0	1,199	1,199	0	1,199	0	1,199
36. Other	0	0	0	0	0	0	0	0
37. Total C	0	0	115,312	115,312	0	115,312	-10,186	105,126
38. Medic	0	0	0	0	0	0	0	0
39. Ancill	0	32,025	2,917	34,942	0	34,942	0	34,942
40. Barbe	0	0	14,375	14,375	0	14,375	0	14,375
41. Coffee	0	0	0	0	0	0	0	0
42	0	0	52,560	52,560	0	52,560	0	52,560
43. Other	102,385	25,460	269,399	397,244	0	397,244	-397,244	0
44. Total S	102,385	57,485	339,251	499,121	0	499,121	-397,244	101,877
45. Grand	1,855,440	321,202	1,156,693	3,333,335	0	3,333,335	-415,194	2,918,141

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	507,436	507,436
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	379,753	379,753
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	4,791	4,791
7. Other Prepaid Expenses	18,355	18,355
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	340,000	340,000
10. Total current assets	1,250,335	1,250,335
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	63,710	63,900
14. Buildings, at Historical Cost	2,130,235	2,190,479
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	590,924	601,095
17. Accumulated Depreciation (book methods)	-1,671,571	-1,708,401
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	7,072	7,072
23. other (specify):	1,234,479	1,162,411
24. Total Long-Term Assets	2,354,849	2,316,556
25. Total Assets	3,605,184	3,566,891
CURRENT LIABILITIES		
26. Accounts Payable	45,544	45,544
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	4,520	4,520
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	144,800	144,800
31. Accrued Taxes Payable	19,357	19,357
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	2,915	2,915
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	2,407	2,407
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	219,543	219,543
LONG TERM LIABILITES		
39. Long-Term Notes Payable	932,608	932,608
40. Mortgage Payable	0	0
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	158,480	158,480
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	1,091,088	1,091,088
46. Total Liabilities	1,310,631	1,310,631
47. Total Equity	2,294,553	2,256,260
48. Total Liabilities and Equity	3,605,184	3,566,891

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,462,650
2. Discounts and Allowances for all Levels	88,380
Subtotal - Inpatient Care	2,551,030
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	197,310
7. Oxygen	0
Subtotal - Ancillary Revenue	197,310
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	14,179
14. Non-Patient Meals	8,609
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	48,277
18. Sale of Supplies to Non-Patients	0
19. Laboratory	5,050
20. Radiology and X-Ray	0
21. Other Medical Services	71,571
22. Laundry	0
Subtotal - Other Operating Revenue	147,686
24. Contributions	433,051
25. Interest and Other Investments Income	3,811
Subtotal - Non-Operating Revenue	436,862
27. Other Revenue (specify):	360,932
28. Other Revenue (specify):	778
Subtotal - Other Revenue	361,710
30. Total Revenue	3,694,598
31. General Services	661,920
32. Health Care	1,309,185
33. General Administration	747,797
34. Ownership	115,312
35. Special Cost Centers	446,561
35. Provider Participation Fee	52,560
37. Other	0
40. Total Expenses	3,333,335
41. Income Before Income Taxes	361,263
42. Income Taxes	0
43. Net Income or Loss for the Year	361,263

Page

1

2

3

4

5

6

7

8

9 Line 16 for mortgage insurance.

10

11

12

13

14

15

16

17

18

19

20

21

22

23